SECTION V:

INDEPENDENT AUDITOR'S REPORT ON DEPARTMENT'S FINANCIAL STATEMENTS AND MANAGEMENT RESPONSE TO THE AUDIT

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

Washington, D.C. 20201

FEB 26 1999

To: The Secretary
Through: DS ____
COS ____
ES ____

From: Inspector General

Subject: Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 1998 (CIN: A-17-98-00015)

PURPOSE

Our purpose is to provide you with our audit report on the Department's Consolidated/Combined Financial Statements for Fiscal Year (FY) 1998. This audit is required by the Government Management Reform Act of 1994.

The attached report reiterates several problems reported at the Health Care Financing Administration (HCFA) and highlights systemic problems noted during seven other operating divisions' financial statement audits.

Following is a summary of the major issues discussed in the Departmentwide audit report.

INFORMATION TEXT

In our opinion, except for the effects of the matters discussed below, the Department of Health and Human Services (HHS) FY 1998 financial statements present fairly, in all material respects, HHS' financial position at September 30, 1998; the consolidated net costs, changes in net position, and custodial activity; and the combined budgetary resources and financing for the year then ended in accordance with the accounting principles described in note 1 to those financial statements.

- ***Medicare contractor accounts receivable***. Medicare contractors did not maintain adequate documentation to support reported accounts receivable activity of $23 billion. As a result, we could not determine if the reported $3.3 billion Medicare accounts receivable balance and activities were fairly presented.

- ***Statements of budgetary resources, financing, and custodial activity.*** Because certain operating divisions (the Administration for Children and Families, the Health Resources and Services Administration, the National Institutes of Health, the Substance Abuse and Mental Health Services Administration, and the Indian Health Service) did not have all their accounting records available, we were unable to complete all necessary audit

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procedures related to these statements' activity. These statements were first prepared by the Department for FY 1998.

As discussed in our report on internal controls, financial reporting continues to be a problem. Although improved from FY 1997, draft financial statements and notes for all divisions, as well as the Departmentwide statements, were again provided late in the audit process. In some instances, adjustments to operating division financial statements were still being made at the end of January 1999, which is about 2 months late. We again report HHS' need for a fully functioning, integrated financial system. We also once again point out the need for timely preparation of trial balances; periodic reconciliations and analyses of material general ledger accounts; and retention of supporting documentation, in auditable form, for reported amounts.

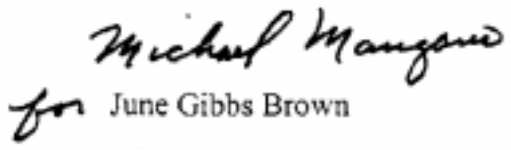
Our report on internal controls notes two other internal control weaknesses that we consider to be material under standards established by the American Institute of Certified Public Accountants and Office of Management and Budget Bulletin 98-08:

1. Significant improvements are still needed in Medicare contractors' development, collection, and reporting of receivable activity.

2. The HCFA central office and HCFA contractors continue to have material internal control weaknesses in electronic data processing controls relating to security access and application development and change controls.

Material weaknesses are those problems that are systemic across a number of operating divisions, as well as significant dollar issues affecting only one division. These weaknesses are synopsized in this report and are fully described in the individual financial statement audit reports which we released separately.

We are grateful for the cooperation the Department has extended to us in performing this audit. If you have any questions, please contact me or have your staff contact Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities, at (202) 619-1157.



Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REPORT ON THE DEPARTMENT OF HEALTH AND HUMAN SERVICES CONSOLIDATED/COMBINED FINANCIAL STATEMENTS FOR FISCAL YEAR 1998

JUNE GIBBS BROWN
Inspector General

FEBRUARY 1999
A-17-98-00015

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

Office of Evaluation and Inspections

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

Office of Investigations

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

INDEPENDENT AUDITOR'S REPORT

INSPECTOR GENERAL'S REPORT ON THE DEPARTMENT OF HEALTH AND HUMAN SERVICES CONSOLIDATED/COMBINED FINANCIAL STATEMENTS FOR FISCAL YEAR 1998

To: The Secretary of Health
and Human Services

We have audited the accompanying consolidated balance sheet of the Department of Health and Human Services (HHS) as of September 30, 1998; the related consolidated statements of net cost, changes in net position, and custodial activity; and the combined statements of budgetary resources and financing (principal financial statements) for the fiscal year (FY) then ended. These financial statements are the responsibility of HHS management. Our responsibility is to express an opinion on these financial statements based on our audit.

Except as discussed in the following paragraphs, we conducted our audit in accordance with generally accepted auditing standards; *Government Auditing Standards* issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 98-08, *Audit Requirements for Federal Financial Statements* (as amended). These standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

Medicare contractor accounts receivable. Medicare contractors used systems for processing claims that did not have general ledger capabilities for Medicare program activity, and they reported accounts receivable activity to the Health Care Financing Administration (HCFA) in periodic financial reports based on subsidiary records maintained on ad hoc spreadsheets. The contractors reported about $23 billion in Medicare accounts receivable activity during the year, which resulted in gross accounts receivable of approximately $5.8 billion, or about $3.3 billion net, at September 30, 1998. We found deficiencies in nearly all facets of Medicare accounts receivable activity at the 12 contractors in our sample. Contractors were unable to support beginning balances; reported incorrect activity, including collections; and/or were unable to reconcile their reported ending balances to subsidiary records. We also found that millions of dollars in receivables had been settled with insurance companies for payments related to situations in which Medicare was the secondary payer (MSP), but these receivables were still

presented as outstanding. Existing internal controls were not adequate to identify receivables that were part of the settlement agreements. As a result, we were unable to satisfy ourselves as to the Medicare contractors' accounts receivable balances and activities for the year ended September 30, 1998.

Statements of custodial activity, budgetary resources, and financing. Because certain operating divisions (the Administration for Children and Families (ACF), the Health Resources and Services Administration (HRSA), the National Institutes of Health (NIH), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Indian Health Service (IHS)) did not have all accounting records available, we were unable to complete all necessary audit procedures related to the statements of custodial activity, budgetary resources, and financing for the year ended September 30, 1998.

As described in note 1, HHS prepared the accompanying principal financial statements in conformity with the hierarchy of accounting principles and standards approved by the Federal Accounting Standards Advisory Board. The hierarchy is a comprehensive basis of accounting other than generally accepted accounting principles.

In our opinion, except for the effects on the financial statements of adjustments, if any, to the principal financial statements that might have been determined to be necessary had we been able to examine evidence regarding Medicare accounts receivable activity and balances as of, and for the year ended, September 30,1998, and had we been able to apply all necessary audit procedures to amounts reported in the statements of custodial activity, budgetary resources, and financing, the principal financial statements referred to above present fairly, in all material respects, the financial position of HHS at September 30, 1998; the consolidated net costs, changes in net position, and custodial activity; and the combined budgetary resources and financing for the year then ended in accordance with the accounting principles described in note 1 to those financial statements.

Our audit was conducted for the purpose of forming an opinion on the principal financial statements referred to in the first paragraph. The information presented in the overview of HHS and the supplemental information of HHS is not a required part of the principal financial statements, but is supplementary information required by OMB Bulletin 97-01, *Form and Content of Agency Financial Statements*. Such information, including trust fund projections, has not been subjected to the auditing procedures applied in the audit of the principal financial statements, and accordingly, we express no opinion on it.

REPORT ON INTERNAL CONTROLS

Except for the matters discussed in our report on the principal financial statements in relation to Medicare accounts receivable and the statements of custodial activity, budgetary resources, and financing, we conducted our audit in accordance with generally accepted auditing standards; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Bulletin 98-08, *Audit Requirements for Federal Financial Statements* (as amended). These standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements referred to above are free of material misstatement.

In planning and performing our audit, we obtained an understanding of internal controls in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and to determine whether the internal controls meet the objectives identified in the following paragraph. Our consideration included obtaining an understanding of the significant internal control policies and procedures; assessing the level of control risk relevant to all significant cycles, classes of transactions, or account balances; and, for those significant internal control policies and procedures that have been properly designed and placed in operation, performing sufficient tests to assess more fully whether the controls are effective and working as designed to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide an opinion on internal control. Accordingly, we do not express such an opinion.

The HHS management is responsible for establishing and maintaining internal controls. In fulfilling this responsibility, estimates and judgments by management are required to assess the expected benefits and related costs of internal control policies and procedures. The objectives of internal controls are to provide management with reasonable, but not absolute, assurance that (1) assets are safeguarded against loss from unauthorized use or disposition, (2) transactions are executed in accordance with management's authorization and recorded properly to permit the preparation of financial statements in accordance with the hierarchy of accounting principles and standards approved by the Financial Accounting Standards Advisory Board, and (3) data that support reported performance measures are properly recorded and accounted for to permit preparation of reliable and complete performance information. Because of inherent limitations in any internal control, errors and irregularities may nevertheless occur and not be detected. Also, projections of any evaluation of internal control to future periods is subject to the risk that procedures may become inadequate because of changes in conditions or that the effectiveness of the design and operation of policies and procedures may deteriorate.

Our consideration of internal controls over financial reporting would not necessarily disclose all matters in these controls that might be reportable conditions. Under standards issued by the

American Institute of Certified Public Accountants, reportable conditions are matters coming to our attention relating to significant deficiencies in the design or operation of internal controls that, in our judgment, could adversely affect HHS' ability to record, process, summarize, and report financial data consistent with the assertions by management in the financial statements. Material weaknesses are reportable conditions in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. However, we noted certain matters discussed below involving internal controls and their operation that we consider to be reportable conditions and material weaknesses.

In addition, with respect to internal controls related to performance measures reported in the *FY 1998 HHS Accountability Report*, we obtained an understanding of the design of significant internal controls related to the existence and completeness assertions, as required by OMB Bulletin 98-08. Our procedures were not designed to provide assurance on internal controls over reported performance measures, and, accordingly, we do not provide an opinion on such controls.

We also considered HHS' internal controls over required supplementary stewardship information by obtaining an understanding of these controls, determining whether the controls had been placed in operation, assessing control risk, and performing tests of controls as required by OMB Bulletin 98-08 and not to provide assurance on these internal controls. Accordingly, we do not provide assurance on such controls.

Using the criteria and the standards established by the American Institute of Certified Public Accountants and OMB Bulletin 98-08, we have identified three internal control weaknesses that we consider to be material, as well as five reportable conditions. A discussion of these matters follows:

MATERIAL WEAKNESSES

1. Financial Reporting

The Chief Financial Officers (CFO) Act imposes important requirements on many Federal agencies, including HHS. Many of these requirements center around the development of annual financial statements in accordance with generally accepted accounting principles for Federal agencies. The OMB Bulletin 97-01 requires that financial statements be the culmination of a systematic accounting process. The statements are to result from an accounting system that is an integral part of a total financial management system containing sufficient structure, effective internal controls, and reliable data.

Although improved from FY 1997, draft financial statements and notes for all operating divisions, as well as the Departmentwide statements, were again provided late in the audit process. In some instances, adjustments to operating division financial statements were still being made at the end of January 1999, which is about 2 months late. In large part, we believe this delay was due to the following conditions:

- Numerous adjusting entries were made late in the fiscal year because periodic reconciliations and account analyses were not performed throughout the year. Further, prior-year adjusting entries necessary to fairly present the HHS and operating division financial statements were not recorded in the accounting records, thus creating additional problems in the current year.

- The HHS accounting records did not capture all data needed to prepare financial statements. For example, information from the Medicare contractors, which was not recorded in the HHS general ledger, needed to be summarized for financial statement presentation.

- The HHS lacked a fully functioning, integrated financial system to produce financial statements in a timely and efficient manner. It relied on manually intensive processes to summarize accounting data into financial statement formats. As a result, the risk of material misstatements was increased. For example, NIH needed to manually summarize information from its 30 institutes and centers to produce financial statements.

A recurring issue involves the numerous adjustments to the financial statements that were required because periodic reconciliations and account analyses were not routinely performed. Reconciliation is an effective internal control for detecting and correcting duplicate postings, omitted entries, or incorrect transfer of data—all of which could result in material misstatements—while account analyses facilitate prompt identification of erroneous or missing transactions. The following examples are indicative of the need for more timely reconciliations and account analyses:

- **Net position**. For the third year, we noted problems in ACF and HRSA net position accounts. Net position accounts are important because they provide critical information on the budgetary status of funds. For example, at ACF and HRSA, the amount reported for undelivered orders (i.e., goods and services ordered but not received), which is a component of one of the net position accounts, differed from the detailed listing of outstanding items by approximately $28 million and $287 million, respectively, as of September 30, 1998. The difference was mainly due to posting journal vouchers for which support was limited and a formal reconciliation was not performed.

- **HCFA expenses.** The reconciliation of "total funds expended" on the HCFA 1522, Monthly Contractor Financial Report, is an important control to ensure that all amounts reported to HCFA by Medicare contractors are accurate, supported, complete, and properly classified. However, 3 of the 12 contractors reviewed did not formally reconcile paid claim activity and "total funds expended." For example, it took several months for these contractors to produce payment tapes that reconciled with the monthly 1522 reports because adjusting entries were not identified and proper cutoff periods were not used.

  Additionally, in many cases, contractors did not have readily available general ledgers and appropriate subsidiary records to support all components of "total funds expended" on the HCFA 1522. For example, to prepare the 1522 reports, contractors had to obtain data from various sources, such as the computerized claims processing system, bank statements, manually prepared documents and ledgers, and estimates. This data was then manually combined by contractors' accountants into the HCFA reporting formats. However, the source documents were not always maintained or accurate. For example, based on our audit work, 4 contractors did not have internal policies and procedures for preparing the HCFA 1522, and 11 contractors did not maintain general ledgers and appropriate subsidiary records to support all components of "total funds expended" on the HCFA 1522.

- **Fund balance.** Reconciliation of agency records with monthly Treasury statements is an important control to prevent irregularities and to ensure that accounting records are accurate. On a monthly basis, NIH is responsible for reconciling approximately 150 Treasury fund balance accounts. During our testing of NIH reconciliations, we noted that (1) adjustments totaling about $216 million relating to prior-year activity were not posted on a timely basis and (2) NIH could not provide support for unreconciled differences in two fund balances with Treasury suspense accounts totaling $7 million. At HRSA, documentation was not available to support differences between general ledger amounts and Treasury amounts totaling $37 million.

  At ACF, the value of periodic reconciliations of the Treasury account is evident. At September 30, 1998, unsupported differences totaled only $9 million, compared with $500 million at September 30, 1997. However, although most differences could be explained, many material differences remained between ACF records and Treasury balances, indicating that transactions were not consistently processed between Treasury and ACF. The ACF should take additional steps to strengthen the reconciliation process.

- **Open document file.** The NIH maintains its outstanding obligations for grants, accounts payable, and accounts receivable subsidiary files in the open document file. This file tracks transactionsn based on a document reference number. Periodic review of open

items is essential because a change or an error in the document reference number will likely result in the appearance of an overpayment or an overstatement of outstanding obligations. We identified approximately 1,800 items totaling $64 million that had not been properly matched—an improvement over the 5,000 unmatched items totaling $272 million in FY 1997.

- **Accounts receivable.** The NIH did not fully analyze its accounts receivable files totaling $114 million to ensure that (1) significant amounts over 1 year old were valid, (2) misclassified Government receivables were corrected, and (3) specific types of transactions that did not represent valid receivables were removed from the subsidiary listing. Of 50 transactions tested, 20 were not valid accounts receivable.

- **Financial statements (statements of custodial activity, budgetary resources, and financing).** Several operating divisions did not have all accounting records available to allow us to complete all necessary audit procedures on three new financial statements required by OMB Bulletin 97-01.

During FY 1998, the Assistant Secretary for Management and Budget (ASMB) and the HHS operating divisions made progress in addressing accounting and financial reporting issues identified in past audits. These efforts resulted in fewer qualifications on the FY 1998 financial statements. The HHS concurred with the Office of Inspector General's (OIG) prior recommendations and reported the need to improve the financial reporting process in its FY 1998 CFO 5-year plan. However, work remains and the progress made must be sustained. The HHS and its operating divisions still need to establish formal policies and procedures to ensure that (1) trial balances, financial statements, and disclosures are timely prepared; (2) reconciliations and account analyses of all material general ledger account balances are routinely performed; and (3) all reported financial statement amounts are supported by complete and auditable documentation. Without these procedures, the financial statement process will continue to be unwieldy and will require an inordinate amount of resources at yearend, substantially delaying issuance of our audit report. Further, without these necessary internal controls, there is no assurance that an unqualified opinion can be issued on future HHS financial statements.

Recommendations. We recommend that ASMB work toward establishing a more formal, structured process capable of producing complete and reliable financial statements in a timely manner and ensure that corrective actions continue on other accounting and control issues identified during audits of the HHS operating divisions.

While resolution of some of these issues may necessitate redesigning some of HHS' accounting systems, other steps can be taken to improve accounting procedures and financial reporting processes if ASMB and the operating division CFO's focus on:

(1) ensuring that accounting staff routinely reconcile and analyze accounts to reduce the number of adjusting entries needed at yearend;

(2) providing additional guidance and training to financial personnel to ensure that they understand the importance of posting entries correctly, performing account analyses and reconciliations, maintaining supporting documentation, and meeting the financial reporting requirements of OMB Bulletin No. 97-01;

(3) assessing whether accounting information is sorted and accumulated in a useful manner to support financial reporting;

(4) taking steps to ensure that recurring transactions are uniformly processed; and

(5) developing yearend closing procedures to ensure completeness.

2. Medicare Contractor Accounts Receivable

During FY 1998, HCFA's Medicare contractors reported accounts receivable activity of about $23 billion and gross yearend receivables of $5.8 billion. This gross amount includes the beginning balance, plus new FY 1998 receivables, less collections/offsets and adjustments (including waivers and writeoffs/transfers). After establishing an allowance for doubtful accounts of $2.5 billion, the net yearend contractor receivable included on HCFA's FY 1998 financial statements totaled about $3.3 billion. Medicare contractor receivables represent about 90 percent of total Medicare receivables of $3.6 billion at September 30, 1998.

These amounts, as reflected in the following table, represent overpayments owed by providers to HCFA, as well as funds due from other entities in instances where Medicare is the secondary payer (MSP).

FY 1998 MEDICARE CONTRACTOR ACCOUNTS RECEIVABLE
(Dollars in billions)

	MSP	Non-MSP	Total
Beginning Balance	$1.9	$2.3	$4.2
New Accounts Receivable	.6	9.5	10.1
Less:			
Collections/Offsets	(.2)	(7.3)	(7.5)
Adjustments/Transfers	(.5)	(.5)	(1.0)
Gross at 9/30/98	**1.8**	**4.0**	**5.8**
Less: Allowance for Uncollectibles	(1.6)	(.9)	(2.5)
Net at 9/30/98	**$.2**	**$3.1**	**$3.3**

As in past years, we found that Medicare contractors did not have adequate subsidiary records and other documentation to determine the validity and completeness of the various accounts receivable components. Because necessary records were not available, we could not perform alternative audit procedures to determine if adjustments were needed.

The HCFA's long-range goal is to standardize contractors' automated systems to pave the way for an integrated accounting system. However, this will require extensive system changes, which are not possible with resources currently allocated to making the agency and its contractors Year 2000 compliant. Short-term corrective actions have focused on using contractors' existing subsidiary systems to improve the quality of data and to identify and document audit trails necessary to support and validate amounts reported to HCFA and used for financial reporting. A further discussion of these matters by type of receivable—MSP and non-MSP—follows.

Questionable MSP Receivables

Medicare is the secondary payer for medical services provided to Medicare-eligible beneficiaries in certain instances, such as when the beneficiaries are covered by their own employer health insurance or that of their spouses. Potential MSP receivables are mainly identified through a data match project operated by the Internal Revenue Service (IRS), the Social Security Administration (SSA), and HCFA. Through this project, SSA produces a list of Medicare beneficiaries by social security number, which IRS matches against tax filings to link the social

security numbers of working beneficiaries and/or beneficiaries with working spouses. The SSA matches these social security numbers against the master earnings file to obtain employer and wage information. The HCFA then sends questionnaires to identified employers to obtain dates of employment and group health insurance coverage. The HCFA and its contractors use this information to identify claims that fall within the time frame that a beneficiary was covered by an employer's group health plan. Potential MSP receivables are also identified through notification by outside sources and through analysis of provider credit balance reports. Without further analysis, the Medicare contractors then bill various group health plans and establish an accounts receivable.

As noted in the table above, contractors reported gross MSP receivables of about $1.8 billion and related reserves for uncollectibles of about $1.6 billion. We found deficiencies in virtually every aspect of the MSP process:

- **Inconsistencies with accounting standards.** The HCFA is reviewing its procedures for recognizing certain MSP receivables for potential inconsistencies with standards as described in the Statement of Federal Financial Accounting Standard No. 1, *Accounting for Selected Assets and Liabilities*, and No. 7, *Accounting for Revenue and Other Financing Sources and Concept for Reconciling Budgetary and Financial Accounting*. These standards recognize receivables when they are specifically identifiable, measurable, and legally enforceable. However, as noted above, we found that HCFA recognized receivables before meeting all the criteria required by these standards, thereby potentially overstating reported receivables.

  Moreover, we noted that HCFA considered the collectibility of MSP receivables as doubtful, as evidenced by a reserve of about 89 percent for these receivables. It is not clear to what extent this reserve, which is based on collection history, reflects inappropriate recognition of receivables versus insufficient collection/offset efforts. Nor is it clear that all MSP activity is captured.

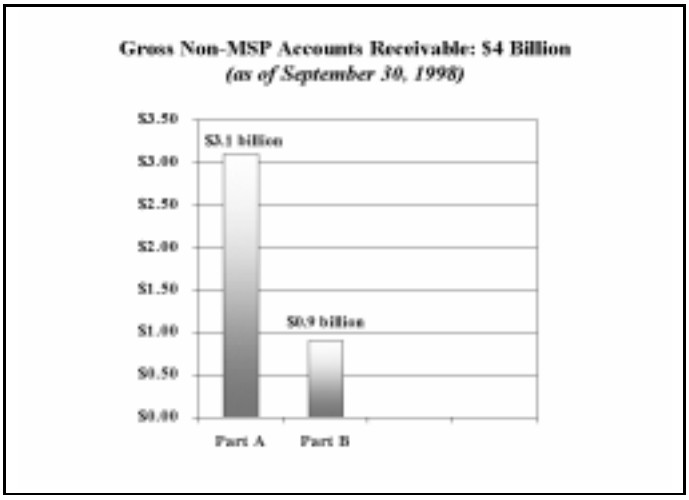
- **Supporting records often not available.** Of the 12 contractors sampled, 7 were not able to adequately support current-year activity and 5 could not support adjustments, including reclassifications, to detailed records. Also, five contractors were unable to reconcile their subsidiary records to MSP amounts reported to HCFA as of September 30, 1998, and three could not provide subsidiary records reconciling to the beginning balance.

  Finally, HCFA has executed settlement agreements with several insurance companies for MSP overpayments. As of September 30, 1998, the amounts of accounts receivable that were related to these settlements had not been determined and adjusted to reflect collections and settlement activity. Consequently, these settled amounts were still

reported as outstanding receivables at yearend. The HCFA is currently in the process of identifying and resolving these settled amounts.

Some Improvement in Non-MSP Receivables

Medicare contractors' non-MSP receivable activity totaled approximately $20 billion during the fiscal year, which resulted in a gross receivable balance of about $4 billion at September 30, 1998. As noted in the chart below, about $3.1 billion, or about 78 percent, of the gross receivables were from Part A institutional providers. Overpayments from Part B providers are typically of small dollar value and involve millions of transactions.



Overall, the Medicare contractors made some improvements in maintaining supporting records for non-MSP related activity and yearend balances. The HCFA focused its efforts to improve documentation on the larger overpayments to Part A institutions. In this regard, HCFA reminded Medicare contractors to maintain receivable documentation, including ledgers and supporting documentation at the transaction level. In addition, HCFA had technical teams review financial data at selected contractors to ensure that records were being maintained. Despite this effort, we continued to find deficiencies.

- **Millions identified in unreconciled variances.** Two contractors had unreconciled variances of more than $44.7 million and $11.9 million, respectively, for cost settlements reported to HCFA. Also, one contractor reported approximately $2 million in reclassifications to cost settlements that were not supported by detailed records, while another reported over $5 million in current-year activity that was not supported by detailed records. Lastly, one contractor reported over $4.5 million in Medicare reclassifications that were not supported by subsidiary records.

- **Lack of controls over collections.** One contractor alone reported $147 million in collections/offsets that were not supported by detailed records. We found that contractors did not maintain subsidiary records to support cash collections and balances reported. Contractors also did not properly segregate duties for cash responsibilities. For example, at one contractor, the same individuals were responsible for receiving and endorsing

incoming checks, preparing and recording deposits, and performing bank reconciliations. In many cases, the contractors did not prepare bank reconciliations in a timely manner and, when prepared, the bank reconciliations were not adequately documented. Lastly, at 1 of the 12 contractors tested, Medicare blank checks were not properly secured or access to blank checks was not always limited.

The HCFA relies on information provided by Medicare contractors to record non-MSP and MSP receivables. However, the HCFA regional offices' oversight procedures often were not adequate or were not performed consistently in all regions to ensure that financial data provided by contractors was reliable, accurate, and complete. For example, we found no procedures for monitoring contractors' Statements of Financial Position (HCFA 750), Status of Accounts Receivable (HCFA 751), or Monthly Contractor Financial Reports (HCFA 1522).

Recommendations. We recommend that ASMB monitor HCFA's corrective actions and develop specific time lines for completion.

3. Medicare Electronic Data Processing

The HCFA relies on extensive data processing operations at both its central office and the Medicare contractors to administer the Medicare program and to process and account for Medicare expenditures.

The HCFA central office maintains administrative data, such as Medicare enrollment, eligibility, and paid claims data, and processes all payments for managed care. In FY 1998, managed care payments totaled $33 billion.

Medicare contractors use one of several "shared" systems to process and pay Medicare fee-for-service claims. As part of this claim processing, the shared systems are to interface, with few exceptions, with the Common Working File (CWF) to obtain authorization to pay claims. The CWF uses seven distributed databases to coordinate Medicare Part A and Part B benefits and to approve claims for payment. The databases are maintained by contractors known as CWF host sites. In addition, the shared systems and CWF are designed and maintained by contractors referred to as system maintainers. These systems accounted for and processed $176.1 billion in Medicare expenditures during FY 1998.

Our review of EDP internal controls covered general and application controls. EDP general controls involve the entity-wide security program, access controls, application development and program change controls, segregation of duties, operating system software, and service continuity. General controls affect the integrity of all applications operating within a single data processing facility and are critical to ensuring the reliability, confidentiality, and availability of

HCFA data. Application controls involve input, processing, and output controls related to specific EDP applications.

We found numerous EDP general control weaknesses at the HCFA central office and the Medicare contractors, as well as application control weaknesses at the contractors' shared systems. Such weaknesses do not effectively prevent (1) unauthorized access to and disclosure of sensitive information, (2) malicious changes that could interrupt data processing or destroy data files, (3) improper Medicare payments, or (4) disruption of critical operations. Further, weaknesses in HCFA's entity-wide security structure do not ensure that EDP controls are adequate and operating effectively. Overall, the weaknesses in the EDP systems environment include many that are material.

- **HCFA central office.** At the HCFA central office, we followed up on the status of the prior year's findings and recommendations. To correct the prior weaknesses in general controls, HCFA has begun several key initiatives, including creating or reengineering oversight activities and awarding task orders to correct specific general control deficiencies. However, because these corrective actions are not scheduled for completion until later in FY 1999, the prior-year material weaknesses dealing with access and application control problems and most of the reportable conditions related to general controls remained unchanged.

- **Medicare contractors.** We completed EDP reviews at a sample of 12 Medicare contractors. In addition, we reviewed general controls at CWF host sites and at the Fiscal Intermediary Shared System (FISS) maintainer and application controls of the FISS, Viable Information Processing System, and CWF.

  We identified material weaknesses in several controls in the FISS and CWF applications. Specifically, FISS edits could be deactivated or bypassed, e.g., the 100 percent duplicate claim edits could be deactivated or bypassed automatically. In limited circumstances, certain claims must bypass CWF edits to be paid. However, these claims need to be reviewed and approved by management. We found paid FISS claims that had bypassed CWF processing and not been subject to such review. Management review of the bypass process needs to be improved and formalized. Additionally, we found six potential duplicate claims in the FISS paid claims file, i.e., the claims were paid by a former Medicare contractor and the claim records were converted to the paid claims file of the newly assigned contractor. Finally, at two contractors, we found instances in which duplicate claims had been paid and processed on the same day but had not been detected by the FISS duplicate edit. The HCFA took immediate action to correct this last problem.

Several other material weaknesses in application and access controls noted last year remained unchanged. For example, we previously reported that data centers had full access to the FISS source code and could perform local changes to FISS programs. Although HCFA now requires contractors to restrict local changes to emergency situations, the local changes are not subjected to the same controls that exist in the standard FISS change process. Additionally, last year's audit disclosed an override library that was developed by one data center to give priority to locally modified FISS programs. Consequently, the local programs always override the standard FISS programs provided by the maintainer. For the Multi-Carrier System, we previously reported that each individual carrier could deactivate HCFA-mandated edits. These prior-year material control issues are still open.

Recommendations. We recommend that ASMB oversee HCFA's continued implementation of corrective actions to address EDP control weaknesses at the Medicare contractors and the central office. Detailed recommendations are contained in the HCFA audit report.

REPORTABLE CONDITIONS

1. Departmental Accounts Payable

Accounts payable internal control deficiencies were identified at most operating divisions. Specific examples follow:

- As a result of HCFA's improvements in its process for estimating Medicare accounts payable, reported at $28.8 billion at September 30, 1998, we no longer consider it a material weakness. However, additional improvements are needed. While data reliability concerns identified in prior years were not present this year, current estimation procedures may not be adequate to detect errors in data used in future projections. Specifically, formal measures still need to be established to periodically determine and document the reasonableness of its accounts payable estimate.

- The NIH did not properly age its accounts payable so that the reported amount could be fully analyzed. At September 30, 1998, we noted over $14 million in accounts payable and $297 million in undelivered orders that related to years earlier than 1995 and that may not be valid liabilities.

- The ACF and HRSA did not liquidate accounts payable and undelivered orders after all goods and services were received and final payment made. At ACF, this condition resulted in an overstatement of $5.3 million in accounts payable and $51.8 million in

- undelivered orders; at HRSA, it caused a $4 million overstatement in accounts payable and $65 million in undelivered orders at September 30, 1998.

Recommendation. We recommend that ASMB oversee the implementation of the corrective actions being taken by HCFA and the other operating divisions.

2. Medicaid Estimated Improper Payments

The Medicaid program, enacted in 1965 under Title XIX of the Social Security Act, is a grant-in-aid medical assistance program financed through joint Federal and State funding and administered by HCFA in partnership with the States, in accordance with approved State plans. Under these plans, a State reimburses providers for medical assistance to individuals found eligible under Title XIX and various other titles of the Act. The 33 million Americans eligible for Medicaid in 1998 included poor families, the disabled, and persons with developmental disabilities requiring long-term care. In FY 1998, State and Federal outlays for Medicaid totaled about $178.7 billion, of which about $98 billion was the Federal share.

No methodology currently exists for estimating the range of improper Medicaid payments on a national level. For the last 3 years, the OIG has reviewed a statistically valid sample of Medicare claims and has determined an estimated range of improper payments out of the total fee-for-service payments processed by HCFA. The majority of the errors fell into four broad categories: insufficient or no documentation, lack of medical necessity, noncovered or unallowable service, and incorrect coding. The results of this sampling have provided HCFA with useful information in helping to reduce overall Medicare improper payments. With no similar methodology in place for the Medicaid program, HCFA is unable to draw any conclusions at the national level on improper Medicaid payments. Since Medicaid is a State-administered program, any estimate of improper payments would need to be performed at the State level.

Recommendation. We recommend that ASMB and HCFA work with the States to develop procedures and implement a methodology for determining the range of improper Medicaid payments.

3. Departmental Electronic Data Processing

The following summarizes some of the systemic EDP control weaknesses identified during audits of the operating divisions' financial statements and service organizations' operations. Other weaknesses are reported in the individual reports on these entities.

- **Program Support Center (PSC).** The PSC operates several computer systems providing accounting and administrative support to HHS operating divisions. The PSC's

Human Resources Service (HRS) is responsible for the HHS Central Personnel and Payroll System. The PSC's Division of Financial Operations (DFO) provides financial management and accounting services to several HHS operating divisions.

As detailed below, we noted three weaknesses in HRS' operations and one weakness in DFO systems that we consider reportable conditions.

- **HRS Central Personnel and Payroll System.** The HRS is not in compliance with the OMB Bulletin A-130 requirement for a comprehensive security plan because its plan lacks key documents, including system security plans, contingency plans, and accreditation statements.

  The HRS also does not have adequate controls over access to sensitive data and systems. For example, only a limited number of data files are protected by a security software program, security personnel have no written criteria for monitoring and restricting access to production data and program files, and security-related positions are understaffed. These vulnerabilities expose HRS' computer systems to risks of external and internal intrusion and subject personnel and payroll information to potential unauthorized access, modification, or disclosure.

  Finally, HRS does not have an up-to-date, comprehensive disaster recovery plan. Its 1990 service continuity plan still has not been updated, although computer operations have changed substantially. Additionally, the Commissioned Corps payroll system does not have a disaster recovery plan.

- **DFO financial management systems.** Some application programmers who make system changes to the accounting system had authority to make and test changes to source code, compile the code, and move the altered code to the production library.

- **NIH.** The NIH's policies and procedures related to requests for systems access need to be strengthened. Further, internal controls over production program and data integrity could be compromised because application programmers had full access to the development, testing, and production environment.

- **Food and Drug Administration (FDA).** Deficiencies noted at FDA included an outdated security program plan, inadequate access controls, insufficient procedures for controlling software changes, and no evidence that its contingency plan had ever been tested.

Recommendations. Specific recommendations to the HHS operating divisions and service organizations are covered in separate reports. We recommend that ASMB oversee their efforts to improve systems access controls, application development and program change controls, and service continuity plans.

4. Property, Plant, and Equipment

In FY 1997, we reported that improvements in accounting for and controlling property, plant, and equipment were needed at NIH and FDA. As noted below, progress has been made in resolving these issues; however, management must make a commitment to sustain this progress.

- **NIH.** The NIH took a number of significant steps to strengthen accounting and internal controls over its $154 million of personal property, including the first complete physical inventory in 5 years to ensure that general ledger balances were accurate. The results of the physical inventory identified $27 million (depreciated value of about $6 million) of capitalized assets that could not be located. Although this is an important first step, the effort will be lost unless NIH develops formal procedures to ensure proper accountability of assets and the monthly reconciliation of general ledger balances with personal property records. As of the end of audit fieldwork, NIH had developed an action plan to identify deficiencies in the accounting of and control over personal property but had not implemented this plan. The NIH has begun implementation of this plan.

  The NIH also made significant strides in improving accountability for its real property valued at about $559 million. The agency conducted a complete physical inventory of its real property, including reevaluation of original cost and accumulated depreciation. However, further corrective action is still needed. For example, NIH did not have a subsidiary system in place to maintain detailed transactions to support reported balances. Further, NIH needs to update formalized policies and procedures to ensure that building-related expenditures meeting the criteria for capitalization are recorded appropriately.

- **FDA.** During FY 1998, FDA completed a physical inventory of accountable personal property and reconciled its subsidiary ledger to the general ledger. Further policies and procedures were put in place for annual complete inventories and quarterly reconciliations of accounting records. However, we continued to find some differences between the property listing and the property on hand. Although these differences did not have a material impact on FDA's financial statements, the cause of these types of discrepancies, if not correctly identified and promptly resolved, could undermine the progress FDA has made.

Recommendations. We recommend that ASMB oversee the implementation of the corrective actions being taken by NIH and FDA. Specific recommendations are provided in separate audit reports.

5. Estimating Losses from Pending Litigation

In FY 1997, we reported that management at several operating divisions did not assess the likelihood of losses from pending claims and lawsuits. Federal accounting standards require agency management to determine whether it is probable that a legal claim will end in a loss and, if it is estimable, to recognize an expense and a liability for the full amount of the expected loss.

In November 1998, HHS issued final guidance to the operating divisions directing that management obtain from counsel an assessment of the likelihood that lawsuits will result in losses. If a loss is probable and the amount is estimable, management is to record that amount in its accounting records.

Recommendation. We recommend that ASMB monitor the implementation of its policy to ensure that operating divisions properly assess the likelihood of possible loss and make proper disclosure where appropriate.

OTHER MATTERS

As part of our audit, we also obtained an understanding of management's process for evaluating and reporting on internal control and accounting systems as required by the Federal Managers Financial Integrity Act (FMFIA) and compared the material weaknesses reported in HHS' FY 1998 FMFIA report that relate to the financial statements under audit to the material weaknesses noted in our report on internal controls. Under OMB's guidelines for FMFIA reporting, HHS reports any deficiency that the Secretary determines to be significant enough to be reported outside the agency in its FMFIA report as a material weakness. This designation requires a judgment by HHS management as to the relative risk and significance of deficiencies. In identifying and assessing the relative importance of deficiencies, HHS management pays particular attention to the views of the HHS Inspector General. Medicare accounts receivable and Medicare EDP, two of the material weaknesses identified in our FY 1998 report on internal controls, were included in the FMFIA report which is being transmitted as part of the FY 1998 HHS Accountability Report. Management did not report our final material weakness, financial reporting, because it believed that this deficiency did not reach the level of significance that required reporting to the President and the Congress under FMFIA.

STATUS OF PRIOR-YEAR INTERNAL CONTROL WEAKNESSES

During FY 1998, HHS and its operating divisions substantially completed corrective actions on three previously reported material weaknesses and reportable conditions. These matters are discussed below.

National Compliance - Medicare Fee-for-Service Error Rate

"Monitoring National Compliance - Medicare Fee-for-Service Error Rate" was included in last year's report as a material weakness. This deficiency focused on the need to develop a routine process for estimating the extent of improper payments in the Medicare program. The HCFA concurred in the need to establish this process as part of its management control plan and will periodically estimate the extent of these improper payments. We consider this condition to be substantially resolved.

Grant Accounting

Last year we noted a material weakness in grant accruals and grant advance reconciliations.

During 1998, HHS refined the accrual methodology by developing two estimates: (1) a yearend estimate of grant expenditures and (2) an estimate for the "incurred but not reported" portion of the accrual, i.e., expenses recorded by grantees but not yet paid and reported to Federal agencies. Through regression analysis of Payment Management System data and a survey of grantees, the Department estimated a grant accrual amount.

The Department also revised its procedures for reconciling grant advances. A new report was developed to assist in the reconciliation, and grant advance amounts are now recorded in the general ledger at the document level.

We commend the Department for the progress made in grant accounting. Regarding grant accruals, the Department needs to either seek OMB approval for a change in expenditure reporting or formalize the procedures now in place. The reconciliation procedures are essential to reconciling subsidiary and general ledger accounts; they provide added assurance that the amounts recorded are valid and properly valued.

Grant Monitoring Using Single Audit Reports

Most Federal grant recipients are required to have an annual audit of each major grant program. These audits, referred to as single audits, are a primary tool for monitoring grantee activity and providing important information on the validity of Federal program expenditures. During FY

1998, the Federal Government centralized its receiving and monitoring of single audit reports at the Census Bureau, Department of Commerce. The HHS audit follow-up work group will be required to coordinate with the Department of Commerce (Single Audit Clearinghouse) to continue to identify and follow up on all HHS grantees with delinquent audits. Due to the Department's current policy and practices, this is no longer a reportable condition.

REPORT ON COMPLIANCE WITH LAWS AND REGULATIONS

Except for the matters discussed in relation to Medicare accounts receivable and the statements of custodial activity, budgetary resources, and financing in our report on the principal financial statements, we conducted our audit in accordance with generally accepted auditing standards; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Bulletin 98-08, *Audit Requirements for Federal Financial Statements* (as amended). These standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements referred to above are free of material misstatement.

The HHS management is responsible for complying with applicable laws and regulations. As part of obtaining reasonable assurance about whether HHS' financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts, and certain other laws and regulations specified in OMB Bulletin 98-08, as amended, including the requirements referred to in the Federal Financial Management Improvement Act (FFMIA) of 1996.

The results of our tests of compliance with laws and regulations, exclusive of FFMIA, disclosed one instance of noncompliance, described below, that is required to be reported under *Government Auditing Standards* and OMB Bulletin 98-08.

The HCFA did not comply with Titles XVIII and XIX of the Social Security Act, as amended, and implemented in regulation 42 of the Code of Federal Regulations (CFR). Specifically, as discussed in detail in our separate report on improper Medicare fee-for-service payments (CIN: A-17-99-00099), and based on our statistically valid sample, we estimate that improper Medicare benefit payments made during FY 1998 totaled $12.6 billion, or about 7.1 percent of the $176.1 billion in processed fee-for-service payments reported by HCFA. This year's estimate is $7.7 billion less than last year's estimate of $20.3 billion and $10.6 billion less than the previous year's estimate of $23.2 billion. These improper payments, as with past years, could range from inadvertent mistakes to outright fraud and abuse. We cannot quantify what portion of the error rate is attributable to fraud. The overwhelming majority (90 percent) of these improper

payments were detected through medical record reviews coordinated by the OIG. When these claims were submitted for payment to Medicare contractors, they contained no visible errors. Although HCFA has made substantial progress in reducing improper payments in the Medicare program, continued efforts are needed.

Under FFMIA, we are required to report whether the agency's financial management systems substantially comply with the Federal financial management systems requirements, Federal accounting standards, and the United States Government Standard General ledger at the transaction level. To meet this requirement, we performed tests of compliance using the implementation guidance for FFMIA included in Appendix D of OMB Bulletin 98-08. The results of our tests disclosed instances where HHS financial management systems did not substantially comply with certain requirements discussed in the preceding paragraph. The following instances of noncompliance have been identified:

- The accounting systems HHS and its operating divisions used were not adequate to prepare reliable and timely financial statements. The process HHS and its operating divisions used to prepare annual financial statements was manually intensive, involving a series of spreadsheets to combine general ledger trial balances with external information from Medicare contractors. Further, numerous adjusting, closing, and elimination entries made outside the general ledger systems needed to be added to these spreadsheets before financial statements could be prepared. Several operating divisions did not have all accounting records available to complete all necessary audit procedures related to the statements of custodial activity, budgetary resources, and financing for the year ended September 30, 1998.

- The HCFA did not have an integrated accounting system to capture expenditures at the Medicare contractor level. Also, HCFA recognized MSP receivables before meeting all the criteria required by Federal accounting standards.

- The HCFA central office and Medicare contractor access and application control weaknesses and deficiencies in the HHS Central Personnel and Payroll System were significant departures from requirements in OMB Circulars A-127, *Financial Management Systems*, and A-130, *Management of Federal Information Resources*.

The HHS CFO has prepared a 5-year plan to address FFMIA and other financial management issues. Although certain milestone dates have passed, we recognize that the plan will require periodic updating to reflect changed priorities and available resources.

An audit of financial statements conducted in accordance with generally accepted auditing standards; the *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Bulletin 98-08, *Audit Requirements for Federal Financial Statements* (as amended) is not designed to determine HHS' readiness for the Year 2000. Further, we have no responsibility with regard to HHS' efforts to make its systems, or any other systems, such as those of HCFA's vendors, service providers, or any other third parties, Year 2000 ready or to provide assurance on whether HHS has addressed or will be able to address all of the affected systems on a timely basis. These are responsibilities of HHS management.

Although we performed tests of the Department's compliance with certain provisions of these laws and regulations, our objective was not to provide an opinion on overall compliance with such provisions. Accordingly, we do not express such an opinion.

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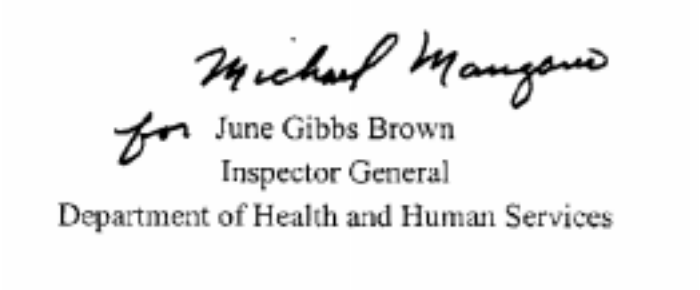
Comments from HHS, which are included as appendix II, have been incorporated in this report where appropriate. We appreciate the cooperation and assistance of HHS staff during this audit.

Additionally, we would like to acknowledge the significant contributions made by the staff of the General Accounting Office.

Our audit was performed in accordance with *Government Auditing Standards* and OMB Bulletin 98-08 and includes (1) examining, on a test basis, evidence supporting amounts and disclosures in the financial statements, (2) consideration and testing of HHS' internal controls for purposes of expressing an opinion on the principal financial statements, and (3) determining whether there are material instances of noncompliance with laws and regulations. Our tests and evaluations of internal controls and compliance with laws and regulations for purposes of expressing an opinion on the principal financial statements in accordance with *Government Auditing Standards* and OMB Bulleting 98-08 would not disclose all internal control weaknesses nor all material noncompliance with laws. Considering this, this report may not be sufficient for other purposes.



February 26, 1999
CIN: A-17-98-00015

Appendix I

FISCAL YEAR 1998 CFO REPORTS ON HHS OPERATING DIVISIONS AND SERVICE ORGANIZATIONS

Separate financial statement audits of eight HHS operating divisions were conducted in FY 1998, including:

- Administration for Children and Families *(CIN: A-17-98-00016),*
- Centers for Disease Control and Prevention *(CIN: A-17-98-00007),*
- Food and Drug Administration *(CIN: A-17-98-00014),*
- Health Care Financing Administration *(CIN: A-17-98-00098),*
- Health Resources and Services Administration *(CIN: A-17-98-00005),*
- Indian Health Service *(CIN: A-17-98-00004),*
- National Institutes of Health *(CIN: A-17-98-00008),* and
- Substance Abuse and Mental Health Services Administration *(CIN: A-17-98-00006).*

Statement on Auditing Standards (SAS) 70 reviews were conducted at:

- Central Payroll and Personnel System, PSC *(CIN: A-17-99-00018),*
- Center for Information Technology, NIH *(CIN: A-17-98-00013),*
- Division of Financial Operations, PSC *(CIN: A-17-98-00009),* and
- Payment Management System, PSC *(CIN: A-17-98-00011*).

Appendix II

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

FEB 25 1999

June Gibbs Brown
Inspector General
U.S. Department of Health and Human Services
Washington, DC 20201

Dear Inspector General Brown:

This letter responds to the Office of Inspector General opinion of the FY 1998 audited financial statements of the U.S. Department of Health and Human Services. Your report lists two qualifications regarding: 1) Medicare accounts receivable and 2) Statements of Budgetary Resources, Financing and Custodial Activity. We are in general agreement with your findings and recommendations. Your report reflects that the Department showed a marked improvement over the two previous years with fewer qualifications and material weaknesses. Significantly, through our joint efforts, we were able to complete the Department's financial statement preparation and the audit process within the March 1 statutory due date for the first time. This progress occurred during a year that instituted new accounting standards and five new financial statements.

We have an aggressive corrective action in place already to resolve the audit findings. Our interim progress is tracked and reported to OMB on a quarterly basis.

I would like to thank your office for its continuing professionalism during the course of the audit as they worked in conjunction with my office to address complex financial accounting issues.

Sincerely,

John J. Callahan
Assistant Secretary for Management and Budget/
Chief Financial Officer